

1 Introduction

There has been increasing policy concern about the costs associated with health care litigation and the financial viability of medical indemnity insurance in Australia. It was recognised by Health Ministers that the systematic collection and analysis of medical indemnity claims data is critical to the nation's ability to understand and monitor the situation.

This report presents the first full financial year's data collected through the Medical Indemnity National Collection (MINC) and provides information on the number, nature, incidence and costs of public sector medical indemnity claims. There is information on the incidents that give rise to claims, the people affected by these incidents, and the size, outcome and key aspects of the processing of claims.

Data for approximately 80% of all claims in the scope of the MINC are included. A claim falls within the scope of the MINC when either legal proceedings have been instigated or the claim is likely to require litigation and has a reserve placed against it. Claims are included if they were current at any time during the reporting period (July 2003–June 2004); that is, those that were open at the start of the period and those that arose during the period.

This is the second report originating from the MINC. The initial report, *First Medical Indemnity National Data Collection Report: Public Sector, January to June 2003* describes the development of the collection and presents the first six months' data. While significant improvements (particularly in regard to data completeness) have occurred, the data presented in this report must be interpreted cautiously as further improvements in quality and scope are needed (see section 2.4, Data quality and completeness). Particular care should be taken when attempting to compare data in this report with those in the previous publication.

1.1 Background to the collection

The need for a national medical indemnity collection arose in the broader context of national policy concern related to health care litigation, associated costs, and the financial viability of medical indemnity insurers. To date, the absence of national data has made it difficult to analyse trends in the number, nature and cost of medical indemnity claims.

At the Medical Indemnity Summit in April 2002, Health Ministers decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies. The Medical Indemnity Data Working Group (MIDWG) was convened under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). On 3 July 2002 AHMAC decided to commission the Australian Institute of Health and Welfare (AIHW) to work with the MIDWG to further develop the proposals of the MIDWG for a national medical indemnity data collection for the public sector.

1.2 Purposes of the collection

The primary purposes of the MINC are:

- to obtain ongoing information on medical indemnity claims and their outcomes;
- to provide a national information base on nationally aggregated data which assist policy makers to identify trends in the nature, incidence and cost of medical indemnity claims; and
- to provide an evidence base from which policy makers can develop and monitor measures to minimise the incidence of medical indemnity claims and the associated costs.

In future, when agreed by the MIDWG, MINC aggregated data may:

- supplement other sources of national medical indemnity claims data, to allow the financial stability of the medical indemnity system to be monitored; and
- supplement other sources of information on clinical risk prevention and management.

Work on the compilation of a single national report incorporating public and private sectors is currently underway. Its completion will be a substantial step towards a meaningful and accurate portrayal of the medical indemnity insurance sector nationwide.

1.3 Collaborative arrangements

The MINC is governed by an Agreement, the parties to which are the Australian Government, state, and territory health departments, and the AIHW. The agreement outlines the respective roles, responsibilities and collaborative arrangements of all parties.

A Medical Indemnity Data Working Group (MIDWG), consisting of members representing all health authorities and the AIHW, manages the development and administration of the MINC. The MIDWG advises on and reaches agreement on all data resource products, aggregated data publications and MINC-related matters. The MIDWG reports on statistical matters to the Statistical Information Management Committee and any unresolved issues are presented to AHMAC for resolution.

AIHW is the national data custodian of the MINC and is responsible for the collection, cleaning, management and reporting of MINC data. High quality data management is ensured by the data custodian through observance of:

- the Information Privacy Principles and National Privacy Principles (*The Privacy Act 1988*) which govern the conduct of all Australian Government agencies and private organisations in their collection, management, use and disclosure of personal records; and
- documented policies and procedures, approved by the board of AIHW, addressing information security and privacy.

MINC jurisdictional data are unidentifiable and treated in confidence by the AIHW in all phases of collection and custodianship. Any release or publication of MINC aggregated data requires the unanimous approval and consent of MIDWG. An annex to the Agreement outlines the protocols for access to and release of MINC data.

1.4 Ongoing development of the collection and progress towards a full national report on medical indemnity

The goal articulated by Health Ministers at the Medical Indemnity Summit in 2002 was to make full national data on public and private sector medical indemnity claims available to inform policy. There are now two relevant collections: the MINC, collecting public sector information, and the Australian Prudential Regulatory Authority (APRA), collecting private sector information covered by public and products liability and professional liability (including medical indemnity) insurance under the *Financial Sector (Collection of Data) Act, 2001*. Both collections hold information on open claims from 1 January 2003; MINC has been collecting data since that year, while APRA's first transmission of data occurred in 2004.

The two collections have evolved with different purposes. MINC collects (in addition to some financial information) data on the nature of claims and the people affected by and involved in allegedly harmful events. APRA is legislatively bound to collect information that will assist in the prudential regulation of insurance agencies. APRA and AIHW have been working together to improve coordination and consistency in data content between the two collections. This has resulted in some changes to data items and coding categories in both the APRA and MINC data specifications. These efforts are expected to continue in an attempt to optimise consistency across the two collections.

A single national report

In 2004 the Australian Government introduced the Premium Support Scheme, as part of a comprehensive medical indemnity package, to assist eligible doctors to meet the cost of their medical indemnity insurance. Under the Premium Support Scheme the Australian Government enters into standard contracts with medical indemnity insurers, which stipulate that medical indemnity insurers must provide information on private sector medical indemnity claims and other information to the Australian Government. These contracts give a mechanism for providing AIHW with data to enable the compilation of a single national medical indemnity report, covering both public and private sectors.

Key stakeholders in medical indemnity data met to discuss the development and coordination of a national report in July 2004 and again in May 2005. These meetings involved representatives from the Medical Indemnity Industry Association of Australia (MIIAA), APRA, Insurance Statistics Australia, MIDWG and the AIHW. Ongoing discussions between all parties have resulted in general agreement about

the importance of data consistency between the collections and of the efficient flow of data between organisations. Since July 2004 the MIIAA members have made significant progress towards meeting the information requirements of the Premium Support Scheme (which include the provision of MINC data). The compilation of a single national report by AIHW is a realistic possibility in the near future (possibly a limited 2003–2004 report and a more complete 2004–2005 report to be published in mid-2006).

2 The collection

2.1 Scope and context

A medical indemnity claim is a claim for compensation for harm or other loss as a result of a health care incident. The MINC contains information on medical indemnity claims that are made against the public sector and managed by state and territory health departments. Claims within the MINC fall within two categories:

- claims on which legal activity has commenced, as indicated, for example by a letter of demand, issue of writ or court proceeding; and
- potential claims that are likely to materialise into a claim, and have a reserve placed against them.

A reserve is the dollar amount of the best current estimate of the total cost of a claim when it is closed. Jurisdictions vary in their reserving practices; however, as the placement of reserves plays a crucial role in defining liability and potential risk, it is likely that the profile of claims within the scope of MINC is similar nation wide. The information provided within MINC is representative of only those incidents that have resulted in legal proceedings, or may be likely to. The collection is therefore not necessarily representative of the wider spectrum of adverse events or iatrogenic harm within the health care system.

Management of public sector medical indemnity insurance varies across jurisdictions. Claims within the MINC are not exclusively limited to public sector patients or publicly employed health professionals. States and territories differ in their indemnity coverage of visiting medical officers, students and private practitioners. Jurisdictions are also in various stages of enacting tort law reform, which may impact the scope, nature and quantum of medical indemnity claims in the future. These variations are explored further in Section 2.2 and Appendix 2.

Data for any one year relate to claims that were current at any time during the year; that is, those that were open at the start of the period and those that arose during the period (including those claims finalised during the period).¹

2.2 Policy, administrative and legal context

Public sector medical indemnity insurance coverage is defined by state legislation and policies vary between jurisdictions. Generally cover is provided where the medical practitioner seeking indemnity has diligently and conscientiously

¹ Finalised claims include claims that have been finalised during the reporting period (827 claims had a date of finalisation in July 2003–June 2004), or which have been finalised before the reporting period but not closed (33 claims had a date of finalisation before July 2003).

endeavoured to carry out their duty and there is no wilful neglect or criminal activity on their part. With the implementation of tort law reform and changes to medical indemnity legislation, the MINC is operating in a changing policy and legal environment. While these reforms aim to improve national consistency in claims management and legal proceedings, variation in jurisdictional medical indemnity arrangements continues. This section describes the differences in state and territory legislation and insurance policy that may affect the nature and scope of MINC claims across Australia. Specific information relating to each jurisdiction is provided in Appendix 2.

Policy relating to public sector medical indemnity

In all states and territories, health professionals employed by public health agencies are indemnified for their public work. The coverage of students (medical and allied health) and academics varies by jurisdiction and may require financial contributions from participating universities.

In recent years changes have been made to public sector medical indemnity policy in response to concerns that rising premiums for doctors in private practice will endanger the availability of important health services. Many jurisdictions have expanded their public sector medical indemnity insurance of private medical practitioners (in specified circumstances) to address these concerns. Examples under this arrangement include:

- non-salaried doctors treating public patients in public hospitals;
- employed doctors with limited private-practice rights entering into fee-sharing arrangements with public hospitals; and
- rural general practitioners working in country health services.

In one jurisdiction indemnity has recently been extended to include clinician involvement in activities such as clinical audits or the investigation of adverse events.

The scope of MINC includes all claims that fall under public sector medical indemnity arrangements. Therefore, as policy relating to coverage changes in jurisdictions, the scope of MINC will change accordingly.

Administrative arrangements and claims management

As a general guide, key steps involved in the claim management process include:

- An incident that may lead to a public sector medical indemnity claim is notified to the relevant claims management body.
- If the likelihood of a claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.
- Various events may signal the commencement of the claim – a writ or letter of demand may be received from the claimant’s solicitor (this may occur before notification), or the defendant may make an offer to the claimant to settle the

matter before a writ or letter of demand has been issued. In some cases no action is taken by the claimant or the defendant.

- The claim is investigated. This may include liaising with clinical risk management staff within the health care facility concerned and seeking expert medical advice.
- As the claim progresses the reserve is monitored and adjusted if necessary.
- A claim may be finalised in various ways, including through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement via statutorily mandated conference processes must be attempted before a claim can go to court. In some cases settlement may be agreed between the claimant and defendant, independent of any formal process.
- A claim file that has remained inactive for a long period may be closed. In some instances claims that have been closed may subsequently be re-opened.

The detail of this process varies between jurisdictions. In some jurisdictions there are different processes for small claims and large claims.

In some jurisdictions claims are largely managed in-house, by the state or territory health authority. Some of the legal work may be outsourced to private law firms. In other jurisdictions most of the claims management process is handled by a body that is separate to the health authority.

Legal reforms

In 2002 Australian, state and territory governments established a panel to review the law of negligence as it applies to claims for personal injury and death. One of the terms of reference of the *Review of the Law of Negligence Report* (resulting in the Ipp Report) was to 'develop and evaluate principled options to limit liability and quantum of awards for damages'.

A key recommendation of the review was that a single statute should be enacted in all jurisdictions to ensure national consistency in proceedings relating to claims for personal injury and death (Commonwealth of Australia 2002). The Ipp Report also made recommendations on a range of issues, including:

- a test for determining the standard of care in cases where negligence is alleged against a medical practitioner;
- reducing the limitation period within which a claim for damages for personal injury or death resulting from negligence may be brought;
- restrictions on the requirement for a defendant to pay a plaintiff's legal costs;
- capping awards for general damages and damages for loss of earning capacity;
- damages relating to mental harm (that these should be recoverable only where there is a recognised psychiatric illness);
- principles guiding the determination of other types of damages (such as health care costs, gratuitous services and future economic loss); and

- a requirement that, under certain circumstances, parties must attend mediation proceedings with a view to securing a structured settlement.

All jurisdictions have legislated limitation periods within which legal action relating to a medical indemnity claim must be initiated, and some have legislation that limits awards of damages for negligence claims for personal injury or death (including medical indemnity claims). There is considerable variation in these provisions between jurisdictions.

To date, all jurisdictions have introduced some tort law reforms consistent with recommendations in the Ipp Report and many are currently engaged in, or planning, further tort reform initiatives. These reforms are designed to:

- decrease the incidence of minor claims;
- improve outcomes for both plaintiffs and defendants; and
- improve the general efficiency of the claims management process.

2.3 Data items

The MINC consists of 21 data items documented in the *Medical Indemnity National Collection (Public sector) Data guide 2003–2004* and summarised in Table 2.1. The data guide is updated annually and provides definitions, a guide for use and a brief history of development for each data item. Key MINC terms are defined in Table 2.2.

An information model was developed to aid the development of the MINC and the data items (Figure 2.1). It depicts relationships between key data entities. The MINC collects information about the claim subject (the person who was the patient during the incident that gave rise to the claim), the incident that gave rise to the claim, the claim itself, and other parties involved (including any other parties alleged to have suffered loss, and health service providers). The claimant (the person who is pursuing the claim) is often also the claim subject; however, the MINC does not collect information about the claimant as such. Records in the MINC database are unidentifiable; that is, they do not contain information that would allow the identification of individuals or health service providers involved in claims.

Health Authorities transmit MINC data to AIHW every six months. The AIHW then collates, analyses and reports on the information. The information transmitted represents the ‘best current knowledge’ of the claim manager about the claim. It is expected that, as more information becomes available, the profile of a claim may change considerably. This report presents the most up-to-date information as at 30 June 2004.² As the MINC matures and works towards greater consistency with the private sector claims data some modifications to data items are expected. However, at present, no significant changes to data items have been made since the first report on this collection.

² It is possible to trace changes to data items over numerous reporting periods through the linkage of claim identifiers; however this is not done for this report.

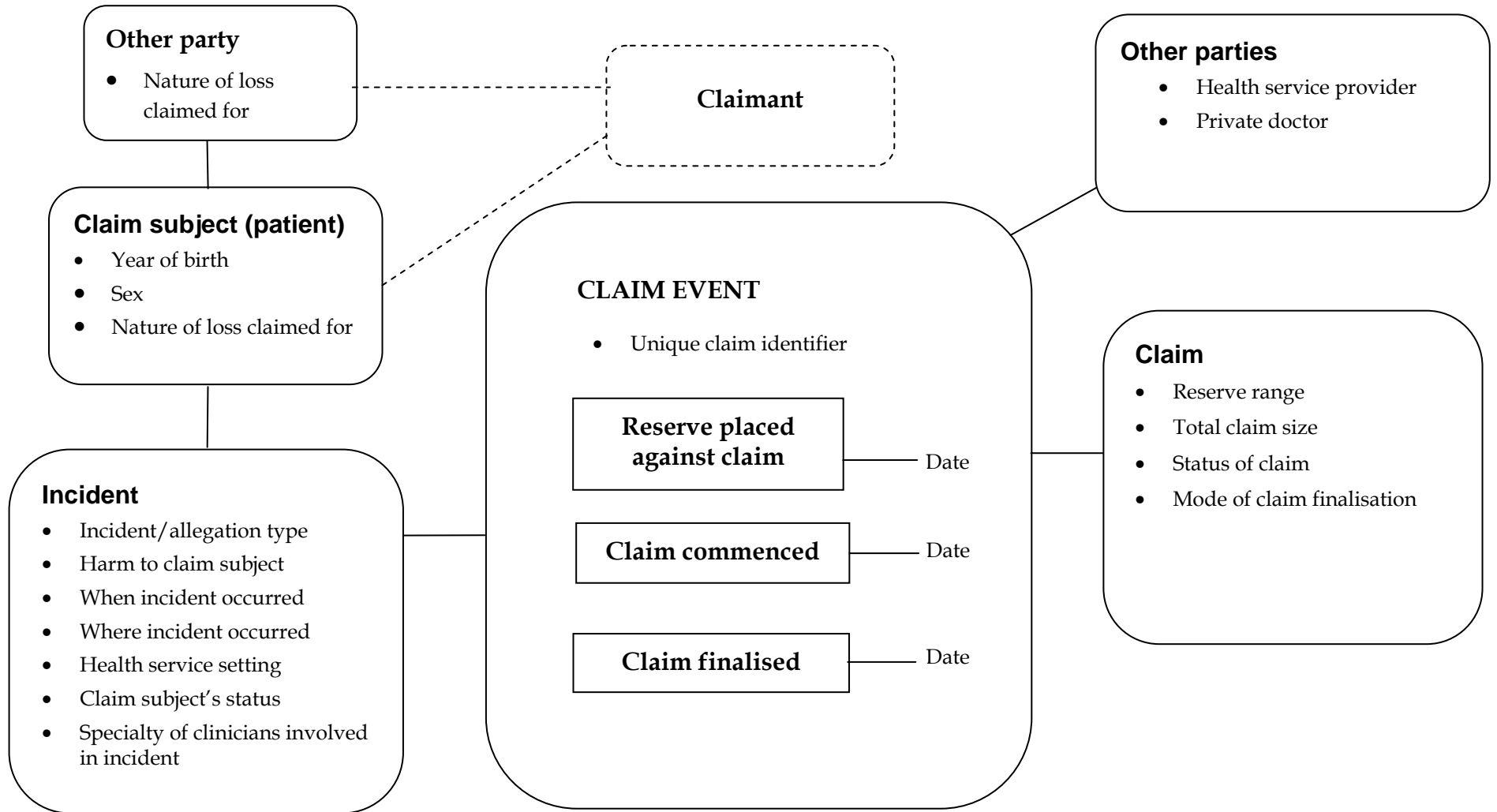
Table 2.1: MINC data items and definitions

| Data item | Definition |
|--|---|
| 1. Claim identifier | An identity number that, within each Health Authority, is unique to a single claim, and which remains unchanged for the life of the claim. |
| 2. Nature of claim—loss to claim subject | A broad description of the categories of loss allegedly suffered by the claim subject (i.e. the patient) that form a basis for this claim. |
| 3. Nature of claim—loss to other party/parties | A broad description of the categories of loss allegedly suffered by an other party or parties (i.e. people other than the patient) that form a basis for this claim. |
| 4. Claim subject's year of birth | Year of birth of claim subject. |
| 5. Claim subject's sex | Sex of the claim subject. |
| 6. Incident/allegation type | The high level category describing what is alleged to have 'gone wrong'; i.e. the area of the possible error, negligence or problem that was of primary importance in giving rise to the claim, reflecting key causal factors. (Up to 3 additional incident/allegation type categories may also be recorded.) |
| 7. Clinical service context | The area of clinical practice or hospital department in which the patient was receiving a health care service when the incident occurred. |
| 8. Body function/structure affected—claim subject | The primary body structure or function of the claim subject (i.e. the patient) alleged to have been affected as a result of the incident. (Up to 3 additional Body function/structure categories may also be recorded.) |
| 9. Extent of harm—claim subject | The extent or severity of the overall harm to claim subject (i.e. the patient). |
| 10. Date incident occurred | Calendar month and year in which the incident that is the subject of the claim occurred. |
| 11. Where incident occurred | Australian Standard Geographical Classification (ASGC) Remoteness Structure category for the location where the incident occurred. |
| 12. Health service setting | Health service provider setting in which the incident giving rise to the claim occurred. |
| 13. Claim subject's status | Whether the claim subject (i.e. the patient) was a public or private, resident or non-admitted patient at the time of the incident. |
| 14. Specialties of clinicians closely involved in incident | Clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim. |
| 15. Date reserve first placed against claim | Calendar month and year in which a reserve was first placed against the claim. |
| 16. Reserve range | The estimated size of the claim, recorded in broad dollar ranges. |
| 17. Date claim commenced | Calendar month and year in which the claim commenced, as signalled by the issue of a letter of demand, issue of writ, an offer made by defendant, or other trigger. |
| 18. Date claim finalised | Calendar month and year in which the claim was settled, or a final court decision was delivered, or the claim file was closed (whichever occurred first). |
| 19. Mode of claim finalisation | Description of the process by which the claim was closed. |
| 20. Total claim size | The amount agreed to be paid to the claimant in total settlement of the claim, plus defence legal costs, recorded in broad dollar ranges. |
| 21. Status of claim | Status of the claim in terms of the stage it has reached in the process from a reserve being set to file closure. |

Table 2.2: Definitions of key MINC terms

| MINC Term | Definition |
|--------------------------------|---|
| Claim | <p>Claim is used as an umbrella term to include medical indemnity claims that have materialised and potential claims.</p> <p>A single claim (i.e. a single record) in the MINC may encompass one or more claims made by a single claimant in respect of a particular health care incident, and may involve multiple defendants.</p> |
| Claimant | The person who is pursuing a claim. The claimant may be the claim subject or may be an other party claiming for loss allegedly resulting from the incident. |
| Claim manager | The person who is responsible for all or some aspects of the management of the claim, on behalf of the Health Authority. |
| Claim subject | The person who received the health care service and was involved in the health care incident that is the basis for the claim , and who may have suffered or did suffer, harm or other loss , as a result. That is, the claim subject is the person who was the patient during the incident. |
| Harm | Death, disease, injury, suffering, and/or disability experienced by a person. |
| Health Authority | The government Department or Agency with responsibility for health care in the Commonwealth of Australia, and in each of the States and Territories of Australia |
| Health care | Services provided to individuals or communities to promote, maintain, monitor, or restore health. |
| Health care incident | An event or circumstance resulting from health care that may have led or did lead to unintended and/or unnecessary harm to a person, and/or a complaint or loss . |
| Incident | In the context of this data collection, 'incident' is used to mean health care incident |
| Loss | Any negative consequence, including financial, experienced by a person. |
| Medical indemnity | Medical indemnity includes professional indemnity for health professionals employed by Health Authorities or otherwise covered by Health Authority professional indemnity arrangements. |
| Medical indemnity claim | A medical indemnity claim is a claim for compensation for harm or other loss that may have resulted or did result from a health care incident . |
| Other party | Any party or parties not directly involved in the health care incident but claiming for loss allegedly resulting from the incident. The 'other party' is not the person who was the patient during the incident. |
| Potential claim | A matter considered by the relevant authority as likely to materialise into a claim , and that has had a reserve placed against it. |
| Reserve | The dollar amount that is the best current estimate of the likely cost of the claim when closed. The amount should include claimant legal costs and defence costs but exclude internal claim management costs. |

Figure 2.1 MINC information model



Key counts

Each record in the MINC represents a single claim, except in some instances where claims brought by family members concerning the one incident are grouped into one claim record. Box 2.1 shows how the data can be used to produce different counts, and these counts are reflected in the tables of Chapter 3.

Box 2.1 Counting rules for the MINC data set

The definition of 'claim' includes 'potential claims' (see section 2.1). Some tables present data for particular sub-sets of claims:

- *Current claims – claims that are open (i.e. have a reserve placed against them but have not been finalised) as at the end of the reporting period (there were **4,096 current claims** as at 30 June 2004).*
- *Finalised claims – claims that have been finalised during the reporting period (827 claims had a date of finalisation of July 2003–June 2004), or which have been finalised before the reporting period but not closed (33 claims had a date of finalisation before July 2003). **A total of 860 claims were finalised** for the period 1 July 2003 to 30 June 2004.*
- *New claims – claims that were opened during the reporting period, including those that were also finalised during the period (there were **1,641 new claims** for the period 1 July 2003 to 30 June 2004).*
- *All claims – the total set of claims in the MINC during the reporting period (i.e. claims open at any time during the period). This is the sum of current and finalised claims, including claims that were open at the start of the period (there were **4,956 claims in total in the MINC database for the period 1 July 2003 to 30 June 2004**).*

For each claim there is one claim subject, except in some cases where more than one family member is bringing an action relating to the same incident.

For some MINC data items more than one code may be recorded per claim. These items are:

- *Nature of claim – loss to claim subject*
- *Nature of claim – loss to other party/parties*
- *Incident/allegation type*
- *Body function/structure affected – claim subject*
- *Specialties of clinicians closely involved in the incident*

For each of these items data may be presented as the number of coding categories recorded (which in most cases will be greater than the number of claims).

2.4 Data quality and completeness

MINC is a newly established collection and, as such, data quality and completeness are still being improved. Over the last two years, several jurisdictions have committed additional resources to the collection and recording of medical indemnity claims in a centralised database. This has resulted in a significant improvement of data completeness since the establishment of the collection in 2002. As the collection matures, data completeness and quality are expected to improve further. In the meantime, interpretation of data needs to be made in the context of data coverage and quality.

Data coverage and completeness

Approximately 80% of claims in the scope of the MINC are reflected in this report. Six jurisdictions have provided 100% of their medical indemnity claims for the period July 2003–June 2004. The following jurisdictions did not provide full data:

- Victoria provided data for 85% of claims in scope for the period. Even though Victoria had in place a claims data collection system that contained more than two decades of claims records, many of the data items in that system did not map readily to data items developed for the MINC. Consequently, at some expense, Victoria has had to manually code all open claims files since 1 January 2003 in addition to any new claims files raised. Of the claims not reported to MINC to date, 79% were current claims and 21% were new in the period. A significant proportion of claims not provided related to rural doctors, community health and ambulance services.

The total dollar value of reserves against claims in scope but not included was just under half of the total dollar value of all Victorian claims in scope. It is anticipated that a complete Victorian data set should be available for inclusion in the 2004–2005 report.

- New South Wales has provided data for 52% of claims in scope. Records were provided for all claims that have been opened since January 2002. Claims in scope for the current reporting period but opened prior to 2002 were not provided to MINC. The claims not provided to MINC have an estimated reserve value equivalent to approximately 70% of the reserve value of all New South Wales claims in scope. As New South Wales claims predating 2002 are finalised and closed they will represent a smaller proportion of claims in scope of MINC, and overall data completeness will improve.

Thus, claims not included in New South Wales and Victoria data have larger reserves than those included.

Missing data

New South Wales data are not included in tables involving the following data items; 'Nature of claim – loss to other party/parties'; 'Additional incident/allegation type'; 'Additional body functions/structures affected – claim subject'; 'Extent of harm –

claim subject'; and 'Specialties of clinicians closely involved in the incident'. Consequently the total number of claims cannot be shown in these tables and data are presented as percentages. New South Wales already had a data system in place with data specifications that differed from those of the MINC and has been unable to provide data for these data items. All other jurisdictions have established or adapted other data systems to comply with MINC specifications.

Data quality

'Not known' rates

The proportion of 'not known' rates remains relatively high for some data items. 'Not known' can be coded when the information is either not currently available but expected to become available, or not expected to ever be available throughout the lifetime of the claim.

For just over half of all claims (57%), 'not known' was recorded for the 'Nature of claim – loss to claim subject' data item (Table 2.3). Similarly, for 54% of all claims (excluding New South Wales) 'not known' was recorded for 'Nature of claim – loss to other parties' (Table 2.3). Information on loss to other parties is not routinely collected by claim managers and MIDWG is currently discussing possible modifications to this data item. Of those claims finalised 29% still had 'not known' coded for this data item.

Several other data items had 'not known' rates between 13% and 17%. These included primary body function/structure affected, claim subject's status, claim subject's year of birth and extent of harm.

For finalised claims, total claim size had a similar 'not known' rate of 13%. More than three-quarters of these claims with total claim size unknown had a claim status of 'claim file closed'.

Medical indemnity claim records will develop over time as further information becomes available. It is recognised that some information may be 'missing' at the time of transmission, but it is expected that the information will become available at a later date.

Table 2.3: MINC data items: number and percentage of claims for which 'not known' was recorded, 1 July 2003 to 30 June 2004

| Items for all states and territories | Number | % of all claims |
|--|---------------|------------------------------|
| Nature of claim—loss to claim subject | 2,805 | 56.6 |
| Claim subject's sex | 46 | 0.9 |
| Primary incident/allegation type | 320 | 6.5 |
| Clinical service context | 193 | 3.9 |
| Primary body function/structure affected | 729 | 14.7 |
| Where incident occurred | 19 | 0.4 |
| Health service setting | 121 | 2.4 |
| Claim subject's status | 660 | 13.3 |
| Finalised claim items | Number | % of finalised claims |
| Mode of claim finalisation | 101 | 11.7 |
| Total claim size | 111 | 12.9 |
| Items for all states and territories except NSW^(a) | Number | % of non-NSW claims |
| Nature of claim—loss to other parties | 2,241 | 53.8 |
| Claim subject's year of birth | 522 | 14.3 |
| Additional incident/allegation types | 6 | 0.2 |
| Additional body functions/structures affected | 5 | 0.1 |
| Extent of harm | 688 | 16.5 |
| Specialties of clinicians closely involved in incident | 124 | 2.5 |

(a) NSW was not able to provide data for any of the data items in the bottom section of the table.

Note: 'Not known' rates are not presented for the following data items, for the reasons stated:

- Date incident occurred: this item must be completed with a valid date for all records included in the MINC.
- Date reserve placed against claim: this item must be completed with a valid date for all records included in the MINC.
- Reserve range: this item must be completed with a valid reserve range category for all records included in the MINC.
- Date claim commenced: it is valid for this item to be left blank for claims that have not yet commenced.
- Date claim finalised: it is valid for this item to be left blank for claims that have not yet been finalised.
- Status of claim: this item must be completed with a valid claim status category for all records included in the MINC.

Coding consistency

Coding consistency can be an issue within and between jurisdictions. Systematic validation checks monitor changes in data items for individual claims between reporting periods. These have highlighted expected and unexpected changes in items and have identified a number of coding errors. As information infrastructure and claim recording procedures improve it is expected that these errors will decrease.

Overall the data indicate a good general understanding of data items and codes. Inconsistencies may exist in the coding of the relatively small number of claims that have been closed and then reopened. The MINC Data Guide states that the date on which a reserve was first set should be recorded as 'date reserve placed' for reopened claims. However, some jurisdictions record the date the claim was reopened instead;

such that the duration of the claim, as calculated from key dates in the MINC, is artificially shortened.

Differences between six-month and financial-year data

This is the second publication of MINC data in the medical indemnity national collection. The first publication, *First Medical Indemnity National Data Collection Report: Public Sector, January to June 2003*, contained the first six months' data. Differences in reporting timeframes, data completeness and general data quality mean that the two reports are not generally comparable. Following improvements in data completeness, additional claims that were in scope for the first report, but not included within it, are now presented in this report. This will also be the case for future annual publications.

2.5 Future directions for MINC

The MINC data collection is currently entering its third year of data transmission and reporting. The collection will continue, with health authorities providing data to AIHW to compile and analyse twice a year. Data completeness has improved by approximately 30% since the first report. As the collection moves towards complete inclusion of all public sector medical indemnity claims, it is expected that more comprehensive analysis and an increasing number of data items will be reported on.

Similar patterns exist in this report to the first national report, indicating the potential value of MINC to consistently represent the profile and trends of medical indemnity claims. In the future, MINC data will be able to identify trends in the nature and cost of medical indemnity claims, which will be crucial for the effective evaluation of tort law reforms and policies aimed at decreasing the incidence and cost of medical indemnity claims. Further to this the compilation of a single national report incorporating public and private sector claims will provide a coherent national picture to inform the evaluation and development of national medical indemnity strategies (see discussion in Section 1.4).

MINC data may also complement data emerging from the patient quality and safety field, such as those collected through incident management or sentinel event systems, and provide a general indication of the proportion of reported public health care incidents that result in litigation.

3 Public sector medical indemnity claims data

The data in this chapter cover claims that were current at any time during the reporting period (July 2003–June 2004); that is, those that were open at the start of the period and those that arose during the period, including those finalised during the period. First a description of the incidents giving rise to the claims is provided, followed by a profile of the people affected. Details of current (including new) claims and finalised claims are also given, in terms of numbers, duration and amounts (reserves and final costs).

3.1 Incidents

This section provides a ‘snapshot’ of the incident giving rise to a claim and the environment in which it occurred. Information will be presented on the event that precipitated a claim (primary incident/allegation type), the clinical context in which the incident occurred and the clinicians who played the most prominent role in the incident (specialty of clinician). Data on the geographic location where the event occurred are also included.

Clinical service context

Clinical service context describes the area of clinical practice or hospital department in which the patient was receiving a health care service when the incident occurred. There are 20 clinical service context categories in the MINC. The tables in this report list the eight most frequently recorded items and collapse all additional items into the category ‘all other clinical service contexts’. This category accounts for 26% of claims. There is also the option for claim managers to code ‘other’ and provide further textual information for clinical contexts that are not included in the classification code list (for example, hospice or intensive care). This was the case for 526 claims (11%).

Between July 2003 and June 2004 the clinical service contexts most frequently recorded were obstetrics (825 claims, or 17% of all claims), accident and emergency (710 claims, or 14%), general surgery (561 claims, or 11%) and gynaecology (414 claims, or 8%) (Table 3.1).

Primary incident/allegation type

Data collected under primary incident/allegation type describe what is alleged to have ‘gone wrong’; that is, the area of the possible error, negligence or problem that was of primary importance in giving rise to a claim. Claims concerning allegations of

procedural-related issues were most commonly recorded (1,627 claims, 33% of all claims), followed by diagnosis (1,028 claims, 21%), treatment (676 claims, 14 %) and other general duty of care (512 claims, 10%) (Table 3.1). Incidents involving device failure and blood/blood-product-related incidents were least commonly recorded.

Incidents associated with procedures were most common in the clinical service contexts of gynaecology (263 claims, 64% of these claims compared with 33% of all claims), general surgery (292 claims, 52%), orthopaedics (185 claims, 48%) and obstetrics (390 claims, 47%). Over half of all claims arising in accident and emergency (414 claims, 58%) were associated with diagnostic issues, compared with 21% of all claims. Diagnostic issues were also relatively common in paediatrics (43 claims, 32%) and general medicine (45 claims, 22%). In claims arising in the psychiatry service context, other general duty of care issues were over-represented (126 claims, 54 % of these claims, compared to 10% overall).

Table 3.1: All claims (public sector): clinical service context by primary incident/allegation type, 1 July to 31 December 2003, Australia

| Clinical service context | Primary incident/allegation type | | | | | | | | | | | | Total (number) | Column per cent | |
|-------------------------------------|----------------------------------|-----------------------------------|-------------|-----------------------------|--------------------------|--------------------------|------------------------|-------------------|----------------|----------------------------|------------|------------|----------------|-----------------|--|
| | Diagnosis | Medication-related ^(a) | Anaesthetic | Blood/blood-product-related | Procedure ^(b) | Treatment ^(c) | Consent ^(d) | Infection control | Device failure | Other general duty of care | Other | Not known | | | |
| | Number of claims | | | | | | | | | | | | | | |
| Obstetrics | 93 | 22 | 21 | 6 | 390 | 167 | 17 | 10 | 1 | 40 | 8 | 50 | 825 | 16.6 | |
| A&E | 414 | 23 | 1 | 1 | 41 | 142 | 4 | 10 | 2 | 42 | 6 | 24 | 710 | 14.3 | |
| General surgery | 68 | 9 | 41 | 3 | 292 | 47 | 30 | 26 | 7 | 22 | 2 | 14 | 561 | 11.3 | |
| Gynaecology | 32 | 3 | 13 | 1 | 263 | 20 | 39 | 2 | 8 | 19 | 2 | 12 | 414 | 8.4 | |
| Orthopaedics | 68 | 4 | 10 | 1 | 185 | 45 | 20 | 17 | 5 | 17 | 2 | 12 | 386 | 7.8 | |
| Psychiatry | 37 | 13 | 1 | — | 2 | 27 | 3 | — | — | 126 | 15 | 10 | 234 | 4.7 | |
| General medicine | 45 | 22 | 2 | 6 | 11 | 36 | 2 | 2 | 4 | 61 | 5 | 8 | 204 | 4.1 | |
| Paediatrics | 43 | 10 | — | 2 | 33 | 22 | 1 | 1 | 2 | 9 | 7 | 5 | 135 | 2.7 | |
| All other clinical service contexts | 214 | 51 | 35 | 48 | 393 | 163 | 69 | 42 | 22 | 163 | 26 | 68 | 1,294 | 26.1 | |
| Not known | 14 | 10 | 2 | 3 | 17 | 7 | 2 | 2 | 2 | 13 | 4 | 117 | 193 | 3.9 | |
| Total (number) | 1.028 | 167 | 126 | 71 | 1.627 | 676 | 187 | 112 | 53 | 512 | 77 | 320 | 4.956 | 100.0 | |
| | (per cent) | | | | | | | | | | | | | | |
| Obstetrics | 11.3 | 2.7 | 2.5 | 0.7 | 47.3 | 20.2 | 2.1 | 1.2 | 0.1 | 4.8 | 1.0 | 6.1 | 100.0 | | |
| A&E | 58.3 | 3.2 | 0.1 | 0.1 | 5.8 | 20.0 | 0.6 | 1.4 | 0.3 | 5.9 | 0.8 | 3.4 | 100.0 | | |
| General surgery | 12.1 | 1.6 | 7.3 | 0.5 | 52.0 | 8.4 | 5.3 | 4.6 | 1.2 | 3.9 | 0.4 | 2.5 | 100.0 | | |
| Gynaecology | 7.7 | 0.7 | 3.1 | 0.2 | 63.5 | 4.8 | 9.4 | 0.5 | 1.9 | 4.6 | 0.5 | 2.9 | 100.0 | | |
| Orthopaedics | 17.6 | 1.0 | 2.6 | 0.3 | 47.9 | 11.7 | 5.2 | 4.4 | 1.3 | 4.4 | 0.5 | 3.1 | 100.0 | | |
| Psychiatry | 15.8 | 5.6 | 0.4 | — | 0.9 | 11.5 | 1.3 | — | — | 53.8 | 6.4 | 4.3 | 100.0 | | |
| General medicine | 22.1 | 10.8 | 1.0 | 2.9 | 5.4 | 17.6 | 1.0 | 1.0 | 2.0 | 29.9 | 2.5 | 3.9 | 100.0 | | |
| Paediatrics | 31.9 | 7.4 | — | 1.5 | 24.4 | 16.3 | 0.7 | 0.7 | 1.5 | 6.7 | 5.2 | 3.7 | 100.0 | | |
| All other clinical service contexts | 7.3 | 5.2 | 1.0 | 1.6 | 8.8 | 3.6 | 1.0 | 1.0 | 1.0 | 6.7 | 2.1 | 60.6 | 100.0 | | |
| Not known | 16.5 | 3.9 | 2.7 | 3.7 | 30.4 | 12.6 | 5.3 | 3.2 | 1.7 | 12.6 | 2.0 | 5.3 | 100.0 | | |
| Total (per cent) | 20.7 | 3.4 | 2.5 | 1.4 | 32.8 | 13.6 | 3.8 | 2.3 | 1.1 | 10.3 | 1.6 | 6.5 | 100.0 | | |

(a) 'Medication-related' includes type and dosage issues, and method of administration issues.

(b) 'Procedure' includes failure to perform a procedure, wrong procedure performed, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) 'Treatment' includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) 'Consent' includes failure to warn.

Notes

- The clinical service context categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
- Data for approximately 80% of all claims in scope are included.
- This table represents the primary incident/allegation type. As well as the primary incident/allegation type category, up to three additional categories may be recorded in the MINC, to describe other aspects of 'what went wrong'.

Specialty of clinician involved in incident

The specialties most commonly represented in medical indemnity claims were obstetrics and gynaecology (977 claims),³ emergency medicine (439 claims), general surgery (378 claims) and orthopaedic surgery (359 claims) (Table 3.2).

The clinical service context and specialty of the clinician involved in an incident often reflect similar areas of health practice. Claims associated with the clinical specialties of obstetrics, emergency medicine, general surgery, gynaecology, orthopaedic surgery, and psychiatry overwhelmingly occurred in closely related clinical service contexts. In the specialty areas of general nursing and general anaesthetics, claims were widely distributed across clinical service contexts.

As numerous health care providers can be closely involved in an incident, MINC provides the opportunity for up to four specialties to be coded. Of all claims 86% involved just one clinician, 11% involved two clinicians and 2% recorded the involvement of three clinicians. Frequencies of all specialties recorded and the extent of additional clinician involvement in a claim can be found in Appendix 3 (Table A3-2).

³ This calculation includes three categories of speciality of clinician: obstetrics only, gynaecology only and obstetrics and gynaecology.

Table 3.2 All claims (public sector): clinical service context by specialties of clinicians involved, 1 July 2003 to 30 June 2004, Australia^(a) (per cent)

| Clinical service context | Specialty of clinician(s) ^(b) | | | | | | | | | | | | | Total |
|-------------------------------------|--|--------------------|-----------------|---------------------|-----------------|------------------|--|----------------------------|--------------|----------------------|-------------------------|------------------------|--------------|--------------|
| | Obstetrics only | Emergency medicine | General surgery | Orthopaedic surgery | Nursing—general | Gynaecology only | Other hospital based medical practitioner ^(c) | Obstetrics and gynaecology | Psychiatry | Anaesthetics—general | Other specialties known | Not N/A ^(d) | | |
| Obstetrics | 98.3 | 0.9 | 1.3 | 0.6 | 5.9 | 1.4 | 11.9 | 57.4 | 0.5 | 24.7 | 13 | 6.5 | — | 18.7 |
| A&E | 0.2 | 92.5 | 4.5 | 11.4 | 12.5 | 1.1 | 40.3 | 1.7 | 5.8 | 1.3 | 5.9 | 2.4 | — | 15.1 |
| General surgery | — | 0.5 | 85.2 | 1.4 | 9.2 | 1.4 | 7.6 | 0.9 | 0.5 | 29.7 | 9.5 | 4.8 | 6.5 | 12.2 |
| Gynaecology | 0.2 | — | 1.3 | — | 6.3 | 92.2 | 7.2 | 38.3 | — | 10.1 | 1.4 | 0.8 | — | 8.9 |
| Orthopaedics | — | 2.1 | 1.1 | 80.5 | 3.6 | — | 6.5 | — | 0.5 | 8.9 | 1.4 | — | 9.7 | 7.6 |
| Psychiatry | — | — | 0.3 | 0.3 | 10.6 | — | 3.2 | — | 89.9 | 0.6 | 0.6 | 1.6 | — | 5 |
| General medicine | 0.2 | 0.7 | 0.8 | — | 17.8 | — | 2.9 | — | — | 3.2 | 9.1 | 1.6 | — | 4.6 |
| Paediatrics | 0.2 | 0.2 | 1.1 | 1.4 | 5.6 | — | 4.3 | 0.4 | — | 2.5 | 7.5 | 0.8 | — | 3.4 |
| All other clinical service contexts | — | 0.5 | 0.3 | 0.3 | 2.6 | 1.1 | 0.7 | 0.4 | — | 2.5 | 1.3 | 66.9 | 3.2 | 2.6 |
| Not known | 0.9 | 2.7 | 4.2 | 4.2 | 25.7 | 2.8 | 15.5 | 0.9 | 2.9 | 16.5 | 50.3 | 14.5 | 80.6 | 22 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total no of claims ^(e) | 459 | 439 | 378 | 359 | 303 | 283 | 278 | 235 | 207 | 158 | 1,625 | 124 | 31 | |

(a) NSW data are not included in this table as NSW data on clinical specialty are not available.

(b) This data item provides information on the clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim. There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault.

(c) 'Other hospital based medical practitioner' includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(d) 'Not applicable' for this data item indicates that no clinical staff were involved in the incident (e.g. where the claim relates to actions of hospital administrative staff).

(e) This is the total number of claims for which the particular specialty was recorded. A given specialty may be recorded only once for a single claim. However, up to four different specialties may be recorded for a claim, so a single claim may be counted in the total for several columns; therefore, these totals cannot be summed horizontally to give the total number of claims overall.

Note: The specialties and clinical service context categories listed separately here are the most frequently recorded categories; all other categories are combined in the categories labelled 'All other specialties' and 'All other clinical service contexts' respectively.

Geographic location

The data in Table 3.3 describe the geographic location where the incident that gave rise to a claim occurred. Almost all claims arose from incidents in major cities (3,369 claims or 68% of all claims) or inner regional areas (1,059 claims or 21%), reflecting the concentration of health services in more densely populated areas. Only 75 claims (2%) related to incidents occurring in remote and very remote areas. Of all clinical contexts, psychiatry had the highest proportion of claims (79%) in major cities, while general surgery and gynaecology had the lowest (60% and 61% respectively).

A relatively high proportion of claims involving neurosurgery, cardiology and psychiatry specialists originated from incidents that occurred in major cities (96%, 84% and 82% respectively), while a relatively low proportion of claims involving general surgery specialists occurred in major cities (58%) (Table 3.4).

Table 3.3: All claims (public sector): clinical service context by geographic location, 1 July 2003 to 30 June 2004, Australia (per cent)

| Clinical service context | Geographic location where incident occurred ^(a) | | | | | Total |
|-------------------------------------|--|----------------|----------------|------------------------|------------|--------------|
| | Major cities | Inner regional | Outer regional | Remote and very remote | Not known | |
| Obstetrics | 67.4 | 21.5 | 9.5 | 1.5 | 0.2 | 100.0 |
| A&E | 65.8 | 22.1 | 10.1 | 1.8 | 0.1 | 100.0 |
| General surgery | 60.2 | 26.4 | 11.2 | 2.1 | — | 100.0 |
| Gynaecology | 60.9 | 24.6 | 12.6 | 1.7 | 0.2 | 100.0 |
| Orthopaedics | 62.2 | 24.9 | 10.9 | 1.3 | 0.8 | 100.0 |
| Psychiatry | 79.1 | 15.8 | 4.7 | — | 0.4 | 100.0 |
| General medicine | 65.7 | 24.0 | 6.9 | 3.4 | 0.0 | 100.0 |
| Paediatrics | 74.8 | 17.0 | 5.2 | 2.2 | 0.7 | 100.0 |
| Not known | 67.9 | 19.2 | 11.9 | 0.5 | 0.5 | 100.0 |
| All other clinical service contexts | 74.6 | 18.0 | 5.6 | 1.2 | 0.7 | 100.0 |
| Total | 68.0 | 21.4 | 8.8 | 1.5 | 0.4 | 100.0 |
| <i>Total number</i> | 3,369 | 1,059 | 434 | 75 | 19 | 4,956 |

(a) The categories for this data item are based on Australian Standard Geographical Classification (ASGC) Remoteness Structure categories (ABS 2001).

Notes

1. The clinical service context categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'.
2. Data for approximately 80% of all claims in scope are included.

Table 3.4: All claims (public sector): specialties of clinicians involved by geographic location, 1 July 2003 to 30 June 2004, Australia^(a) (per cent)

| Specialty of clinician(s) ^(b) | Geographic location of incidents | | | | Total | Total number of claims ^(c) |
|--|----------------------------------|----------------|----------------|------------------------|-------|---------------------------------------|
| | Major cities | Inner regional | Outer regional | Remote and very remote | | |
| Obstetrics only | 69.7 | 22.2 | 6.8 | 1.1 | 100.0 | 459 |
| Emergency medicine | 67.9 | 22.1 | 8.9 | 1.2 | 100.0 | 439 |
| General surgery | 57.4 | 27.8 | 11.4 | 3.4 | 100.0 | 378 |
| Orthopaedic surgery | 64.3 | 21.7 | 12.3 | 1.7 | 100.0 | 359 |
| Nursing—general | 68.6 | 18.8 | 8.6 | 4.0 | 100.0 | 303 |
| Gynaecology only | 61.8 | 26.5 | 9.9 | 1.8 | 100.0 | 283 |
| Other hospital based medical practitioner ^(d) | 68.7 | 14.7 | 10.8 | 5.8 | 100.0 | 278 |
| Obstetrics and gynaecology | 72.3 | 14.0 | 12.3 | 1.3 | 100.0 | 235 |
| Psychiatry | 81.6 | 15.5 | 2.9 | — | 100.0 | 207 |
| Anaesthetics—general | 67.1 | 23.4 | 8.2 | 1.3 | 100.0 | 158 |
| Midwifery | 63.2 | 18.4 | 14.0 | 4.4 | 100.0 | 114 |
| General and internal medicine | 65.8 | 22.5 | 9.9 | 1.8 | 100.0 | 111 |
| Diagnostic radiology | 75.6 | 19.2 | 5.1 | — | 100.0 | 78 |
| Urology | 73.3 | 21.3 | 5.3 | — | 100.0 | 75 |
| Cardiology | 83.6 | 14.9 | 1.5 | — | 100.0 | 67 |
| Neurosurgery | 95.5 | — | 4.5 | — | 100.0 | 67 |
| All other specialties | 76.0 | 14.8 | 7.1 | 2.0 | 100.0 | 1,113 |
| Not applicable ^(e) | 83.9 | 16.1 | — | — | 100.0 | 31 |
| Not known | 68.5 | 18.5 | 11.3 | 1.6 | 100.0 | 124 |

(a) NSW data are not included in this table as NSW data on clinical specialty are not available.

(b) This data item provides information on the clinical specialties of the health care providers who played the most prominent roles in the incident that gave rise to the claim (up to four codes may be recorded). There is no implication that the health care providers whose specialties are recorded for this data item were negligent or at fault.

(c) This is the total number of claims for which the particular specialty was recorded. A given specialty may only be recorded once for a single claim. However, up to four different specialties may be recorded for a claim, so a single claim may be counted in the total for several rows; therefore these totals cannot be summed vertically to give the total number of claims overall.

(d) 'Other hospital based medical practitioner' includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(e) 'Not applicable' for this data item indicates that no clinical staff were involved in the incident (e.g. where the claim relates to actions of hospital administrative staff).

Note: The clinical specialties listed separately here are the sixteen most frequently recorded specialties; all other specialties are combined in the row labelled 'All other specialties'.

3.2 People

This section describes factors relating to the person immediately affected by the incident. Key data items relating to the person are: age at incident from which the claim arose, sex and primary body function/structure affected.

Sex and age at incident

Almost three quarters of claim subjects were adults 18 years and older (3,523 claims, 71% of all claims) (Table 3.5). Babies (<1 year) and children (1-18 years) comprised 9% (431 claims) and 8% (413 claims) of all claims, respectively. Information on age was not supplied for 589 claims (12%).

Females represented more than half (58%) of all claims involving adults and 56% of all claims in total (2,759 claims). Males were involved in 2,151 claims overall (43%), with 51% of claims relating to children and 53% of claims relating to babies.

Female adults were relatively more likely to be involved in procedural-related incidents than other persons (66% of the 1,192 claims in this category). Of claims related to treatment, babies were involved in 15% (105 of 676) of claims compared with 8% overall. Children were involved in 142 claims (14%) concerning allegations relating to diagnosis, compared with 8% overall; and female children were more likely than male children to be involved in claims involving duty-of-care issues (21 claims or 68% of the 31 claims in this group).

Table 3.5: All claims (public sector): sex and age at incident of claim subject, by primary incident/allegation type, 1 July 2003 to 30 June 2004, Australia

| Primary incident/ allegation type | Age at incident | | | | Total ^(a) |
|-----------------------------------|-----------------|---------------------|-------------------|------------|----------------------|
| | Baby (<1 year) | Child (1–<18 years) | Adult (18+ years) | Not known | |
| Males | | | | | |
| Diagnosis | 44 | 80 | 354 | 37 | 515 |
| Medication | 7 | 7 | 53 | 10 | 77 |
| Anaesthetic | 1 | 1 | 41 | 2 | 45 |
| Blood/blood-product-related | 2 | 4 | 27 | 2 | 35 |
| Procedure | 90 | 41 | 401 | 48 | 580 |
| Treatment | 49 | 31 | 189 | 33 | 302 |
| Consent | 5 | 9 | 52 | 7 | 73 |
| Infection control | 3 | 4 | 41 | 10 | 58 |
| Device failure | 2 | 8 | 15 | 2 | 27 |
| Other general duty of care | 10 | 10 | 192 | 34 | 246 |
| Other | 2 | 1 | 33 | 4 | 40 |
| Not known | 14 | 8 | 75 | 56 | 153 |
| <i>Total males</i> | <i>229</i> | <i>204</i> | <i>1,473</i> | <i>245</i> | <i>2,151</i> |
| Females | | | | | |
| Diagnosis | 26 | 62 | 383 | 40 | 511 |
| Medication | 11 | 6 | 64 | 7 | 88 |
| Anaesthetic | 1 | 1 | 70 | 8 | 80 |
| Blood/blood-product-related | — | 3 | 19 | 6 | 28 |
| Procedure | 69 | 52 | 791 | 123 | 1,035 |
| Treatment | 50 | 41 | 236 | 41 | 368 |
| Consent | 3 | 5 | 98 | 8 | 114 |
| Infection control | — | 3 | 41 | 6 | 50 |
| Device failure | — | 3 | 20 | 2 | 25 |
| Other general duty of care | 5 | 21 | 203 | 35 | 264 |
| Other | — | 5 | 27 | 5 | 37 |
| Not known | 14 | 6 | 97 | 42 | 159 |
| <i>Total females</i> | <i>179</i> | <i>208</i> | <i>2,049</i> | <i>323</i> | <i>2,759</i> |
| Persons^(b) | | | | | |
| Diagnosis | 70 | 142 | 737 | 79 | 1,028 |
| Medication | 19 | 13 | 117 | 18 | 167 |
| Anaesthetic | 2 | 2 | 111 | 11 | 126 |
| Blood/blood-product-related | 2 | 7 | 46 | 16 | 71 |
| Procedure | 170 | 94 | 1,192 | 171 | 1,627 |
| Treatment | 105 | 72 | 425 | 74 | 676 |
| Consent | 8 | 14 | 150 | 15 | 187 |
| Infection control | 3 | 7 | 63 | 20 | 93 |
| Device failure | 2 | 11 | 54 | 5 | 72 |
| Other general duty of care | 15 | 31 | 395 | 71 | 512 |
| Other | 2 | 6 | 60 | 9 | 77 |
| Not known | 33 | 14 | 173 | 100 | 320 |
| Total | 431 | 413 | 3,523 | 589 | 4,956 |

(a) This column includes 589 claims for which age at incident of claim subject was missing (245 males, 323 females).

(b) Persons includes 46 claims for which sex of claim subject was not known/indeterminate (23 babies, 1 child, 1 adult, 21 not known).

Note: Data for approximately 80% of all claims in scope are included.

Primary body function/structure

The data item 'primary body function/structure' reflects the function or structure that is alleged to be most affected as a result of the incident. Neuromusculo-skeletal and movement-related structures/functions were most commonly reported (23% of all claims), followed by genitourinary and reproductive (14%) and mental functions/structures of the nervous system (13%). Death occurred in 9% of claims. Data relating to body functions/structures must be interpreted cautiously due to the high rate of 'not known' responses (15%).

Table 3.6: All claims (public sector): primary body function/structure^(a) affected, 1 July 2003 to June 2004, Australia

| Primary body function/structure affected | Number | Per cent of all claims |
|--|--------------|------------------------|
| Mental functions/structures of the nervous system | 635 | 12.8 |
| Sensory functions/ the eye, ear and related structures | 144 | 2.9 |
| Voice and speech functions/structures involved in voice and speech | 74 | 1.5 |
| Functions/ structures of the cardiovascular, haematological, immunological and respiratory systems | 334 | 6.7 |
| Functions and structures of the digestive, metabolic and endocrine systems | 425 | 8.6 |
| Genitourinary and reproductive functions and structures | 679 | 13.7 |
| Neuromusculo-skeletal and movement-related functions and structures | 1,117 | 22.5 |
| Functions and structures of the skin and related structures | 218 | 4.4 |
| Death | 456 | 9.2 |
| No body function/structure affected | 145 | 2.9 |
| Not known | 729 | 14.7 |
| All claims | 4,956 | 100.0 |

(a) See Appendix 1 for explanation of coding categories for body function/structure affected.

Note: Data for approximately 80% of all claims in scope are included.

3.3 Claims

Claim status

For the financial year 2003–2004, half of all claims were ‘commenced (not yet finalised)’, 32% were considered potential claims with ‘reserve placed but not yet commenced’ and 17% were finalised (Table 3.7).

Of those claims finalised, the majority were closed (765 claims, 89%) and 4% (34 claims) were finalised under a structured settlement arrangement. A structured settlement involves the payment of awarded damages periodically rather than in a lump sum. It is expected that this number will increase following recent policy recommendations that favour this form of settlement (in some jurisdictions).

Only 40 claims (1% of all claims) were previously closed and reopened during the collection period. Claims may be reopened in cases where additional relevant information becomes available; for example, in cases of a latent disease or delayed harm after a medical procedure.

Of all finalised claims 33% (283 claims) were related to a procedural issue, 21% (184 claims) were related to diagnosis and 14% (116 claims) involved issues related to treatment (Table 3.8). Of claims involving a blood/blood-product-related incident a substantial proportion were not yet commenced (46 claims or 65% compared with 32% overall).

Table 3.7: All claims (public sector): status of claim, 30 June 2004, Australia

| Clinical service context | Reserve placed but not yet commenced ^(a) | Commenced (not yet finalised) ^(b) | Finalised in reporting period | | | | Total finalised ^(g) | Claim previously closed now reopened ^(h) | Total |
|--------------------------|---|--|----------------------------------|---|--|---|--------------------------------|---|-------|
| | | | Claim file closed ^(c) | Awaiting determination of total size ^(d) | Structured settlement with total dollar value decided ^(e) | Structured settlement with total dollar value open ^(f) | | | |
| All claims | 1,591 | 2,465 | 765 | 61 | 32 | 2 | 860 | 40 | 4,956 |
| Total (%) | 32.1 | 49.7 | 15.4 | 1.2 | 0.6 | — | 17.4 | 0.8 | 100.0 |

(a) 'Reserve placed but not yet commenced' indicates that a reserve has been set for the claim but none of the events signalling claim commencement (e.g. the issuing of a letter of demand or a writ, or an offer made by the defendant to the claimant) have yet occurred.

(b) 'Commenced (not yet finalised)' indicates that the claim has commenced but has not yet been finalised.

(c) 'Claim file closed' indicates that the total claim size has been determined, and the claim file has been closed; excludes finalised claims where payments to the claimant are made under a structured settlement scheme.

(d) 'Awaiting determination of total size' indicates that the claim has been finalised but the total claim size has yet to be determined; the claim file has not yet been closed; this may include instances where legal costs have yet to be finally determined.

(e) 'Structured settlement with total dollar value decided' indicates that the claim has been finalised and the Health Authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme with the total amount to be paid decided.

(f) 'Structured settlement with total dollar value open' indicates that the claim has been finalised and the Health Authority has undertaken to make payments to the claimant over a period of time under a structured settlement scheme, with the total amount to be paid remaining open.

(g) Of the 860 finalised claims, 33 had a 'date claim finalised' before the reporting period (before July 2003).

(h) 'Claim previously closed now reopened' indicates that the claim has previously been recorded as finalised on the MINC database, but has then been re-opened.

Note: Data for approximately 80% of all claims in scope are included.

Table 3.8: All claims (public sector): status of claim by primary incident/allegation type, 30 June 2004, Australia

| Primary incident/ allegation type | Finalised | | | | | | | | | | |
|--------------------------------------|-------------------|-------------------------------|-------------------|---|---|--|-----------------|----------------------------|--------------------------------------|--------------|------------------|
| | Not yet commenced | Commenced (not yet finalised) | Claim file closed | Awaiting determination of total size ^(a) | Structured settlement with total dollar value decided | Structured settlement with total dollar value open | Total finalised | Total finalised (per cent) | Claim previously closed now reopened | Total | Total (per cent) |
| Diagnosis | 291 | 545 | 161 | 16 | 6 | 1 | 184 | 21.4 | 8 | 1,028 | 20.7 |
| Medication-related ^(b) | 45 | 104 | 15 | 1 | 1 | — | 17 | 2.0 | 1 | 167 | 3.4 |
| Anaesthetic | 42 | 59 | 22 | 1 | — | — | 23 | 2.7 | 2 | 126 | 2.5 |
| Blood/blood-product-related | 46 | 21 | 3 | — | 1 | — | 4 | 0.5 | — | 71 | 1.4 |
| Procedure ^(c) | 586 | 746 | 249 | 27 | 7 | — | 283 | 32.9 | 12 | 1,627 | 32.8 |
| Treatment ^(d) | 235 | 314 | 105 | 5 | 6 | — | 116 | 13.5 | 11 | 676 | 13.6 |
| Consent ^(e) | 15 | 131 | 32 | 7 | 2 | — | 41 | 4.8 | — | 187 | 3.8 |
| Infection control | 32 | 58 | 18 | 1 | 3 | — | 22 | 2.6 | — | 112 | 2.3 |
| Device failure | 13 | 28 | 9 | 2 | — | — | 11 | 1.3 | 1 | 53 | 1.1 |
| Other general duty of care | 158 | 260 | 83 | — | 6 | 1 | 90 | 10.5 | 4 | 512 | 10.3 |
| Other | 17 | 40 | 18 | 1 | — | — | 19 | 2.2 | 1 | 77 | 1.6 |
| Not known | 111 | 159 | 50 | — | — | — | 50 | 5.8 | — | 320 | 6.5 |
| All claims | 1,591 | 2,465 | 765 | 61 | 32 | 2 | 860 | 100.0 | 40 | 4,956 | 100.0 |
| <i>Total (per cent)</i> | <i>32.1</i> | <i>49.7</i> | <i>15.4</i> | <i>1.2</i> | <i>0.6</i> | <i>—</i> | <i>17.4</i> | | <i>0.8</i> | <i>100.0</i> | |

(a) 'Awaiting determination of total size' indicates that the claim has been finalised but the total claim size has yet to be determined and the claim file has not yet been closed; this may include instances where legal costs have yet to be finally determined.

(b) 'Medication related' includes type and dosage issues, and method of administration issues.

(c) 'Procedure' includes failure to perform a procedure, wrong procedure, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(d) 'Treatment' includes delayed treatment, treatment not provided, complications of treatment, failure of treatment and other treatment-related issues.

(e) 'Consent' includes failure to warn.

Note: Data for approximately 80% of all claims in scope are included.

Categories of loss claimed

The data item 'Nature of claim—loss to claim subject' provides an indication of the categories of loss allegedly suffered by the claim subject. The average number of loss categories recorded was 2.4 per claim (Table 3.9). The most common category of loss recorded was pain and suffering, in 32% of claims, followed by other economic loss (21%) and care costs (18%). A high percentage of all claims had 'not known' recorded for this data item (57%) (this is discussed in more detail in Section 2.4).

Table 3.9: All claims (public sector): nature of claim—loss to claim subject, 1 July 2003 to 30 June 2004, Australia (per cent)

| Nature of claim— loss to claim subject | Care costs^(a) | Other economic loss^(b) | Pain and suffering^(c) | Other loss^(d) | N/A | Not known | Average no. of loss categories^(e) |
|---|-------------------------------------|--|---|-------------------------------------|------------|----------------------|---|
| Per cent of all claims | 18.1 | 20.8 | 31.6 | 14.2 | 7.8 | 56.6 | 2.4 |
| Total number of claims ^(f) | 896 | 1,032 | 1,567 | 703 | 388 | 2,805 | |

- (a) 'Care costs' include long-term care costs, covering both past and future care costs, whether provided gratuitously or otherwise.
- (b) 'Other economic loss' includes past and future economic loss and past and future out-of-pocket expenses; excludes care costs.
- (c) 'Pain and suffering' includes nervous shock and temporary or ongoing disability; includes general damages.
- (d) 'Other loss' includes any other loss claimed for, and includes medical costs (both past and future). Medical costs are costs associated with medical treatment, e.g. doctor's fees, hospital expenses.
- (e) The average number of coding categories for the data item 'Nature of claim—loss to claim subject' recorded per claim (the average is calculated excluding claims for which 'not applicable' or 'not known' was recorded for 'Nature of claim—loss to claim subject').
- (f) This is the total number of claims for which the particular loss category was recorded. A given loss category may only be recorded once for a single claim. However, several loss categories may be recorded for a single claim, so a single claim may be counted in the total for several columns; therefore, these totals cannot be summed horizontally to give the total number of claims overall.

Notes

- For the NSW data included in this table, loss categories recorded for 'Nature of claim—loss to claim subject' may include loss to other parties, as this is not possible to separately identify.
- Data for approximately 80% of all claims in scope are included.

Duration of all claims

The duration of a claim provides useful information that may assist in monitoring the efficacy of claims management policies, the allocation of resources during claims administration and the assessment of litigation burden on plaintiffs (such as additional stress experienced during the claim settlement process).

The average duration of claims in scope for the reporting period was 20 months (1.6 years, Table 3.10). This was longer for finalised claims, which had a mean duration of 28 months (2.3 years). Within finalised claims those settled with the total dollar value undecided and those awaiting determination of total size had been open, on average, for the longest period of time (50 months and 38 months, respectively). In 207 cases (4.2% of all claims) the claim had been open in excess of five years, as at 30 June 2004.

Although small in number, claims that have been closed and then re-opened may appear of shorter duration than they actually are, as there is some variability between jurisdictions in the coding of the date the reserve was placed for these claims (refer to discussion of coding consistency in Section 2.4).

The duration of current and finalised claims is discussed later in the report (see Tables 3.13 and 3.15). It is likely that the mean duration in Tables 3.10, 3.13 and 3.15 is an underestimate, as 45% of New South Wales claims (opened pre-2002, but still current) are not included.

Table 3.10: All claims (public sector): status of claim by length of claim (months)

| Status of claim ^(a) | Length of claim at 30 June 2004 (months) | | | | | | | | | | | Total | Mean |
|---|--|--------------|-------------|-------------|------------|------------|------------|------------|------------|------------|------------|--------------|-------------|
| | <6 | 6–12 | 13–18 | 19–24 | 25–30 | 31–36 | 37–42 | 43–48 | 49–54 | 55–60 | 60+ | | |
| Reserve placed but not yet commenced | 350 | 403 | 353 | 222 | 117 | 73 | 15 | 12 | 11 | — | 35 | 1,591 | 15.8 |
| Commenced (not yet finalised) | 421 | 521 | 412 | 388 | 251 | 141 | 87 | 53 | 71 | 31 | 89 | 2,465 | 20.5 |
| Finalised claims | | | | | | | | | | | | | |
| Claim file closed | 102 | 174 | 166 | 86 | 52 | 43 | 20 | 19 | 21 | 8 | 74 | 765 | 26.3 |
| Awaiting determination of total size | 1 | 4 | 9 | 9 | 5 | 4 | 11 | 4 | 5 | 2 | 7 | 61 | 37.9 |
| Structured settlement with total dollar value decided | — | 2 | 1 | 2 | 7 | 9 | 2 | 3 | 3 | 3 | — | 32 | 34.8 |
| Structured settlement with total dollar value undecided | — | — | — | — | — | — | 1 | — | — | — | 1 | 2 | 50.1 |
| <i>Total finalised^(b)</i> | <i>103</i> | <i>180</i> | <i>176</i> | <i>97</i> | <i>64</i> | <i>56</i> | <i>34</i> | <i>26</i> | <i>29</i> | <i>13</i> | <i>82</i> | <i>860</i> | <i>27.5</i> |
| Claim previously closed now reopened | 3 | 5 | 3 | 4 | 1 | 6 | 4 | 4 | 8 | 1 | 1 | 40 | 32.7 |
| Total claims | 877 | 1,109 | 944 | 711 | 433 | 276 | 140 | 95 | 119 | 45 | 207 | 4,956 | 20.3 |
| | | | | | | (per cent) | | | | | | | |
| Reserve placed but not yet commenced | 22.0 | 25.3 | 22.2 | 14.0 | 7.4 | 4.6 | 0.9 | 0.8 | 0.7 | — | 2.2 | 100.0 | |
| Commenced (not yet finalised) | 17.1 | 21.1 | 16.7 | 15.7 | 10.2 | 5.7 | 3.5 | 2.2 | 2.9 | 1.3 | 3.6 | 100.0 | |
| Finalised claims | | | | | | | | | | | | | |
| Claim file closed | 13.3 | 22.7 | 21.7 | 11.2 | 6.8 | 5.6 | 2.6 | 2.5 | 2.7 | 1.0 | 9.7 | 100.0 | |
| Awaiting determination of total size | 1.6 | 6.6 | 14.8 | 14.8 | 8.2 | 6.6 | 18.0 | 6.6 | 8.2 | 3.3 | 11.5 | 100.0 | |
| Structured settlement with total dollar value decided | — | 6.3 | 3.1 | 6.3 | 21.9 | 28.1 | 6.3 | 9.4 | 9.4 | 9.4 | — | 100.0 | |
| Structured settlement with total dollar value undecided | — | — | — | — | — | — | 50.0 | — | — | — | 50.0 | 100.0 | |
| <i>Total finalised^(b)</i> | <i>12.0</i> | <i>20.9</i> | <i>20.5</i> | <i>11.3</i> | <i>7.4</i> | <i>6.5</i> | <i>4.0</i> | <i>3.0</i> | <i>3.4</i> | <i>1.5</i> | <i>9.5</i> | <i>100.0</i> | |
| Claim previously closed now reopened | 7.5 | 12.5 | 7.5 | 10.0 | 2.5 | 15.0 | 10.0 | 10.0 | 20.0 | 2.5 | 2.5 | 100.0 | |
| Per cent of all claims | 17.7 | 22.4 | 19.0 | 14.3 | 8.7 | 5.6 | 2.8 | 1.9 | 2.4 | 0.9 | 4.2 | 100.0 | |

(a) See Table 3.7 for definitions of status of claim categories.

(b) Of the 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but claim file was still open at July 2003.

Notes

1. Length of claim is from date reserve placed to 30 June 2004. If a claim has a status of 'claim file closed', length of claim is from date reserve placed to date claim finalised.
2. Data for approximately 80% of all claims in scope are included.

Current claims

Of all MINC claims, 83% (4,096 claims) were current; that is, they had not been finalised by the end of the financial year (Table 3.11).

Just over half (52%) of all current claims had a reserve range less than \$30,000. Claims within this reserve range (less than \$30,000) accounted for a greater proportion of claims in the clinical service contexts of psychiatry (65%), general medicine (63%) and accident and emergency (58%).

Claims with a reserve range greater than \$500,000 were over-represented in the clinical service contexts of paediatrics and obstetrics, accounting for 14%, and 13% of such claims respectively, compared with 5% overall.

The majority of claims in the incident/allegation type categories of anaesthetic and other general duty of care had a reserve less than \$30,000 (64% and 63% of claims respectively) (Table 3.12). Almost half (42%) of blood/blood-product-related incidents involved claims with a reserve between \$50,000 and \$100,000.

Table 3.11: Current claims (public sector): reserve range by clinical service context, 30 June 2004, Australia

| Reserve range | Obstetrics | A&E | General surgery | Gynaecology | Orthopaedics | Psychiatry | General medicine | Paediatrics | All other clinical service contexts | Not known | Total |
|-------------------------|--------------|--------------|-----------------|--------------|--------------|--------------|------------------|--------------|-------------------------------------|--------------|--------------|
| Number | | | | | | | | | | | |
| Less than \$10,000 | 93 | 134 | 37 | 108 | 57 | 32 | 43 | 10 | 201 | 56 | 771 |
| \$10,000–<\$30,000 | 203 | 213 | 113 | 147 | 89 | 86 | 70 | 33 | 350 | 61 | 1,365 |
| \$30,000–<\$50,000 | 49 | 54 | 51 | 58 | 44 | 17 | 22 | 15 | 100 | 6 | 416 |
| \$50,000–<\$100,000 | 132 | 93 | 65 | 101 | 48 | 23 | 21 | 27 | 202 | 16 | 728 |
| \$100,000–<\$250,000 | 89 | 51 | 51 | 43 | 44 | 17 | 14 | 16 | 114 | 6 | 445 |
| \$250,000–<\$500,000 | 48 | 20 | 18 | 9 | 11 | 4 | 5 | 5 | 45 | 2 | 167 |
| \$500,000 or more | 91 | 31 | 4 | 4 | 6 | 4 | 4 | 17 | 34 | 9 | 204 |
| <i>Total (number)</i> | <i>705</i> | <i>596</i> | <i>339</i> | <i>470</i> | <i>299</i> | <i>183</i> | <i>179</i> | <i>123</i> | <i>1,046</i> | <i>156</i> | <i>4,096</i> |
| (per cent) | | | | | | | | | | | |
| Less than \$10,000 | 13.2 | 22.5 | 10.9 | 23.0 | 19.1 | 17.5 | 24.0 | 8.1 | 19.2 | 35.9 | 18.8 |
| \$10,000–<\$30,000 | 28.8 | 35.7 | 33.3 | 31.3 | 29.8 | 47.0 | 39.1 | 26.8 | 33.5 | 39.1 | 33.3 |
| \$30,000–<\$50,000 | 7.0 | 9.1 | 15.0 | 12.3 | 14.7 | 9.3 | 12.3 | 12.2 | 9.6 | 3.8 | 10.2 |
| \$50,000–<\$100,000 | 18.7 | 15.6 | 19.2 | 21.5 | 16.1 | 12.6 | 11.7 | 22.0 | 19.3 | 10.3 | 17.8 |
| \$100,000–<\$250,000 | 12.6 | 8.6 | 15.0 | 9.1 | 14.7 | 9.3 | 7.8 | 13.0 | 10.9 | 3.8 | 10.9 |
| \$250,000–<\$500,000 | 6.8 | 3.4 | 5.3 | 1.9 | 3.7 | 2.2 | 2.8 | 4.1 | 4.3 | 1.3 | 4.1 |
| \$500,000 or more | 12.9 | 5.2 | 1.2 | 0.9 | 2.0 | 2.2 | 2.2 | 13.8 | 3.3 | 5.8 | 5.0 |
| <i>Total (per cent)</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> |

Notes

1. The clinical service context categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
2. Data for approximately 80% of all claims are included.

Table 3.12: Current claims (public sector): reserve range by primary incident/allegation type, 30 June 2004, Australia (per cent)

| Reserve range | Primary incident/allegation type | | | | | | | | | | | Total | |
|-------------------------|----------------------------------|-----------------------------------|--------------|-----------------------------|--------------------------|--------------------------|------------------------|-------------------|----------------|----------------------------|--------------|--------------|--------------|
| | Diagnosis | Medication-related ^(a) | Anaesthetic | Blood/blood-product-related | Procedure ^(b) | Treatment ^(c) | Consent ^(d) | Infection control | Device failure | Other general duty of care | Other | | Not known |
| Less than \$10,000 | 142 | 31 | 30 | 12 | 215 | 107 | 18 | 24 | 9 | 82 | 11 | 90 | 771 |
| \$10,000–<\$30,000 | 249 | 47 | 36 | 15 | 463 | 188 | 32 | 23 | 12 | 184 | 21 | 95 | 1,365 |
| \$30,000–<\$50,000 | 86 | 15 | 8 | 2 | 134 | 61 | 26 | 11 | 11 | 49 | 7 | 6 | 416 |
| \$50,000–<\$100,000 | 165 | 21 | 11 | 28 | 252 | 89 | 36 | 19 | 7 | 52 | 12 | 36 | 728 |
| \$100,000–<\$250,000 | 103 | 14 | 14 | 7 | 165 | 55 | 16 | 7 | 2 | 36 | 5 | 21 | 445 |
| \$250,000–<\$500,000 | 39 | 9 | 3 | 2 | 53 | 23 | 12 | 3 | 1 | 10 | 1 | 11 | 167 |
| \$500,000 or more | 60 | 13 | 1 | 1 | 62 | 37 | 6 | 3 | 0 | 9 | 1 | 11 | 204 |
| <i>Total (number)</i> | <i>844</i> | <i>150</i> | <i>103</i> | <i>67</i> | <i>1,344</i> | <i>560</i> | <i>146</i> | <i>90</i> | <i>42</i> | <i>422</i> | <i>58</i> | <i>270</i> | <i>4,096</i> |
| | (per cent) | | | | | | | | | | | | |
| Less than \$10,000 | 16.8 | 20.7 | 29.1 | 17.9 | 16.0 | 19.1 | 12.3 | 26.7 | 21.4 | 19.4 | 19.0 | 33.3 | 18.8 |
| \$10,000–<\$30,000 | 29.5 | 31.3 | 35.0 | 22.4 | 34.4 | 33.6 | 21.9 | 25.6 | 28.6 | 43.6 | 36.2 | 35.2 | 33.3 |
| \$30,000–<\$50,000 | 10.2 | 10.0 | 7.8 | 3.0 | 10.0 | 10.9 | 17.8 | 12.2 | 26.2 | 11.6 | 12.1 | 2.2 | 10.2 |
| \$50,000–<\$100,000 | 19.5 | 14.0 | 10.7 | 41.8 | 18.8 | 15.9 | 24.7 | 21.1 | 16.7 | 12.3 | 20.7 | 13.3 | 17.8 |
| \$100,000–<\$250,000 | 12.2 | 9.3 | 13.6 | 10.4 | 12.3 | 9.8 | 11.0 | 7.8 | 4.8 | 8.5 | 8.6 | 7.8 | 10.9 |
| \$250,000–<\$500,000 | 4.6 | 6.0 | 2.9 | 3.0 | 3.9 | 4.1 | 8.2 | 3.3 | 2.4 | 2.4 | 1.7 | 4.1 | 4.1 |
| \$500,000 or more | 7.1 | 8.7 | 1.0 | 1.5 | 4.6 | 6.6 | 4.1 | 3.3 | 0.0 | 2.1 | 1.7 | 4.1 | 5.0 |
| <i>Total (per cent)</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> | <i>100.0</i> |

(a) Medication related' includes type and dosage issues, and method of administration issues.

(b) 'Procedure' includes failure to perform procedure, wrong procedure, wrong body site, post-operative complications, failure of procedure, and other procedure-related issues.

(c) 'Treatment' includes delayed treatment, treatment not provided, complications of treatment, failure of treatment, and other treatment-related issues.

(d) 'Consent' includes failure to warn.

Note: Data for approximately 80% of claims are included.

Duration of current claims

The mean duration of current claims was 19 months (Table 3.13). Claims with a reserve range of less than \$10,000 had an average duration of 15 months, while claims with a reserve in excess of \$500,000 had been open, on average, for 37 months. Of claims with a duration longer than five years reserve ranges between \$50,000 and \$100,000 (38 claims, or 30% of the claims in this category) were most common, followed by reserves greater than \$500,000 (24 claims, 19%).

Table 3.13: Current claims (public sector): reserve range by length of claim (months)

| Reserve range | Length of claim at 30 June 2004 (months) | | | | | | | | | | | Total | Mean |
|-------------------------------|--|-------------|-------------|-------------|------------|------------|------------|------------|------------|------------|------------|--------------|-------------|
| | <6 | 6–12 | 13–18 | 19–24 | 25–30 | 31–36 | 37–42 | 43–48 | 49–54 | 55–60 | 60+ | | |
| Less than \$10,000 | 197 | 200 | 139 | 114 | 63 | 30 | 4 | 7 | 8 | 3 | 6 | 771 | 14.7 |
| \$10,000–<\$30,000 | 299 | 330 | 303 | 186 | 111 | 72 | 24 | 12 | 13 | 6 | 9 | 1,365 | 15.7 |
| \$30,000–<\$50,000 | 58 | 93 | 89 | 78 | 32 | 17 | 15 | 4 | 13 | 1 | 16 | 416 | 19.5 |
| \$50,000–<\$100,000 | 133 | 183 | 110 | 85 | 70 | 41 | 23 | 18 | 20 | 7 | 38 | 728 | 20.4 |
| \$100,000–<\$250,000 | 47 | 76 | 73 | 81 | 50 | 33 | 20 | 15 | 16 | 10 | 24 | 445 | 24.3 |
| \$250,000–<\$500,000 | 21 | 29 | 18 | 31 | 21 | 9 | 9 | 8 | 10 | 3 | 8 | 167 | 25.3 |
| \$500,000 or more | 19 | 18 | 36 | 39 | 22 | 18 | 11 | 5 | 10 | 2 | 24 | 204 | 36.7 |
| Total | 774 | 929 | 768 | 614 | 369 | 220 | 106 | 69 | 90 | 32 | 125 | 4,096 | 18.8 |
| | (per cent) | | | | | | | | | | | | |
| Less than \$10,000 | 25.6 | 25.9 | 18.0 | 14.8 | 8.2 | 3.9 | 0.5 | 0.9 | 1.0 | 0.4 | 0.8 | 100.0 | |
| \$10,000–<\$30,000 | 21.9 | 24.2 | 22.2 | 13.6 | 8.1 | 5.3 | 1.8 | 0.9 | 1.0 | 0.4 | 0.7 | 100.0 | |
| \$30,000–<\$50,000 | 13.9 | 22.4 | 21.4 | 18.8 | 7.7 | 4.1 | 3.6 | 1.0 | 3.1 | 0.2 | 3.8 | 100.0 | |
| \$50,000–<\$100,000 | 18.3 | 25.1 | 15.1 | 11.7 | 9.6 | 5.6 | 3.2 | 2.5 | 2.7 | 1.0 | 5.2 | 100.0 | |
| \$100,000–<\$250,000 | 10.6 | 17.1 | 16.4 | 18.2 | 11.2 | 7.4 | 4.5 | 3.4 | 3.6 | 2.2 | 5.4 | 100.0 | |
| \$250,000–<\$500,000 | 12.6 | 17.4 | 10.8 | 18.6 | 12.6 | 5.4 | 5.4 | 4.8 | 6.0 | 1.8 | 4.8 | 100.0 | |
| \$500,000 or more | 9.3 | 8.8 | 17.6 | 19.1 | 10.8 | 8.8 | 5.4 | 2.5 | 4.9 | 1.0 | 11.8 | 100.0 | |
| Per cent of all claims | 18.9 | 22.7 | 18.8 | 15.0 | 9.0 | 5.4 | 2.6 | 1.7 | 2.2 | 0.8 | 3.1 | 100.0 | |

Notes

1. Length of claim is from date reserve placed to 30 June 2004.
2. Data for approximately 80% of all claims in scope are included.

Finalised claims

There were 860 finalised claims as at 30 June 2004 (including 827 claims finalised during 2003–2004 and 33 claims finalised before the period) (Box 2.1). More than one-third of finalised claims had a total claim size of less than \$10,000 (37% or 318 claims, Table 3.14). Another 148 claims (17%) had ‘no payment made’.

Mode of claim finalisation describes the process by which the claim was finalised. Of finalised claims, 340 (40%) were settled out of court. Within this group, the majority were settled by other processes (282 claims); for instance, part-way through a trial. Relatively few claims were settled through state or territory complaints processes or statutorily mandated compulsory conference processes (3%, or 11 claims, in both cases). Of claims with a total claim size exceeding \$100,000, 82% (50 claims) were settled out of court compared with 16% (10 claims) decided in court.

Only 48 finalised claims (6%) were settled by a court decision. Almost half (43%) of finalised claims were discontinued. Of those discontinued 56% (207 claims) resulted in a total claim size of less than \$10,000 and for 33% (122 claims) no payment was made. Of those claims finalised through a court decision, almost half resulted in no payment being made.

In 11% of cases, information on either the mode of claim finalisation or the total claim size was not yet known.

Table 3.14: Finalised claims (public sector): total claim size by mode of claim finalisation, 1 July 2003 to 30 June 2004, Australia

| Total claim size | Settled | | | | Settled— other ^(d) | Total settled | Court decision | Dis- continued ^(e) | Not known | Total ^(f) |
|--------------------------------|---|---|---|------------|----------------------------------|---------------|-------------------|----------------------------------|------------|----------------------|
| | State/Territory complaints processes ^(a) | Court-based alternative dispute resolution processes ^(b) | Statutorily mandated compulsory conference process ^(c) | | | | | | | |
| Less than \$10,000 | 6 | 6 | 1 | 86 | 99 | 6 | 207 | 6 | 318 | |
| \$10,000–<\$30,000 | 3 | 7 | 2 | 61 | 73 | 2 | 34 | 1 | 110 | |
| \$30,000–<\$50,000 | 1 | 3 | 1 | 36 | 41 | 1 | 3 | — | 45 | |
| \$50,000–<\$100,000 | 1 | 9 | 5 | 48 | 63 | 4 | — | — | 67 | |
| \$100,000–<\$250,000 | — | 4 | 1 | 24 | 29 | 4 | — | 1 | 34 | |
| \$250,000–<\$500,000 | — | 3 | 1 | 7 | 11 | 1 | — | — | 12 | |
| \$500,000 or more | — | 3 | — | 7 | 10 | 5 | — | — | 15 | |
| No payment made ^(g) | — | — | — | 4 | 4 | 20 | 122 | 2 | 148 | |
| Not known | — | 1 | — | 9 | 10 | 5 | 5 | 91 | 111 | |
| Total | 11 | 36 | 11 | 282 | 340 | 48 | 371 | 101 | 860 | |

(a) 'State/territory-based complaints processes' includes proceedings conducted in state/territory health rights and health complaints bodies.

(b) 'Court-based alternative dispute resolution processes' includes mediation, arbitration, and case appraisal provided under civil procedure rules.

(c) 'Statutorily-mandated compulsory conference processes' include settlement conferences required by statute as part of a pre-court process.

(d) 'Settled—other' includes instances where a claim is settled part way through a trial.

(e) 'Discontinued' includes claims that have been closed due to withdrawal by claimant, or operation of statute of limitations, or where the claim manager decides to close the claim file because of long periods of inactivity. Discontinued also includes instances where a claim is discontinued part way through a trial.

(f) Of the 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but claim file was still open at July 2003.

(g) 'No payment made' is used where the claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Note: Data for approximately 80% of all claims in scope are included.

Duration of finalised claims

The average duration of finalised claims was two years (Table 3.15). Duration was longer for those claims with a total claim size of \$500,000 or more, and where no payment was made (both four years). In 82 cases (9.5% of all claims) the claim had been open in excess of five years.

It is possible that the mean durations are an underestimate, given 45% of open New South Wales claims (predating 2002) are not included.

Table 3.15: Finalised claims (public sector): total claim size by length of claim (months)

| Total claim size | Length of claim at 30 June 2004 (years) | | | | | | Total claims ^(a) | Mean | |
|--------------------------------|---|-------------|-------------|------------|------------|------------|-----------------------------|------------|--|
| | 1 | 2 | 3 | 4 | 5 | >5 | | | |
| Less than \$10,000 | 143 | 96 | 35 | 13 | 11 | 20 | 318 | 1.8 | |
| \$10,000–<\$30,000 | 34 | 35 | 19 | 11 | 4 | 7 | 110 | 2.3 | |
| \$30,000–<\$50,000 | 16 | 13 | 6 | 4 | 4 | 2 | 45 | 2.0 | |
| \$50,000–<\$100,000 | 16 | 23 | 15 | 4 | 5 | 4 | 67 | 2.2 | |
| \$100,000–<\$250,000 | 7 | 13 | 6 | 1 | 7 | — | 34 | 2.2 | |
| \$250,000–<\$500,000 | 1 | 2 | 4 | 2 | 1 | 2 | 12 | 3.2 | |
| \$500,000 or more | 1 | 3 | 3 | 3 | 2 | 3 | 15 | 4.1 | |
| No payment made ^(b) | 36 | 30 | 25 | 13 | 4 | 40 | 148 | 3.7 | |
| Not known | 29 | 58 | 7 | 9 | 4 | 4 | 111 | 1.8 | |
| All claims | 283 | 273 | 120 | 60 | 42 | 82 | 860 | 2.3 | |
| | (per cent) | | | | | | | | |
| Less than \$10,000 | 45.0 | 30.2 | 11.0 | 4.1 | 3.5 | 6.3 | 100.0 | | |
| \$10,000–<\$30,000 | 30.9 | 31.8 | 17.3 | 10.0 | 3.6 | 6.4 | 100.0 | | |
| \$30,000–<\$50,000 | 35.6 | 28.9 | 13.3 | 8.9 | 8.9 | 4.4 | 100.0 | | |
| \$50,000–<\$100,000 | 23.9 | 34.3 | 22.4 | 6.0 | 7.5 | 6.0 | 100.0 | | |
| \$100,000–<\$250,000 | 20.6 | 38.2 | 17.6 | 2.9 | 20.6 | — | 100.0 | | |
| \$250,000–<\$500,000 | 8.3 | 16.7 | 33.3 | 16.7 | 8.3 | 16.7 | 100.0 | | |
| \$500,000 or more | 6.7 | 20.0 | 20.0 | 20.0 | 13.3 | 20.0 | 100.0 | | |
| No payment made ^(b) | 24.3 | 20.3 | 16.9 | 8.8 | 2.7 | 27.0 | 100.0 | | |
| Not known | 26.1 | 52.3 | 6.3 | 8.1 | 3.6 | 3.6 | 100.0 | | |
| All claims | 32.9 | 31.7 | 14.0 | 7.0 | 4.9 | 9.5 | 100.0 | | |

(a) Of the 860 finalised claims, 827 were finalised during 2003–2004 and 33 were finalised previously but the claim file was still open at July 2003.

(b) 'No payment made' is used where the claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence costs.

Notes

1. Length of claim is from date reserve placed to 30 June 2004. If a claim has a status of 'claim file closed', length of claim is from date reserve placed to date claim finalised.
2. Data for approximately 80% of all claims in scope are included.

New claims

There were 1,641 new claims in the period 1 July 2003 to 30 June 2004 (Table 3.16). A new claim has a date reserve placed within the reporting period. Claims with a reserve range between \$10,000 and less than \$30,000 represented the highest proportion of all new claims (35%) and those with a reserve exceeding \$500,000 comprised the smallest (2%). The most common clinical service contexts recorded for new claims were accident and emergency (16%, 261 claims), obstetrics (14%, 231 claims) and general surgery (12%, 188 claims). Obstetrics claims were over-represented in claims with reserves exceeding \$100,000 (44 claims or 22%), compared with 14% of claims overall. Claims associated with psychiatry were relatively more likely to have a reserve below \$30,000 (79% compared with 62% of claims overall).

Table 3.16: New claims (public sector): reserve range by clinical service context, 1 July 2003 to 30 June 2004, Australia

| Reserve range | A&E | Obstetrics | General surgery | Orthopaedics | Gynaecology | General medicine | Psychiatry | Paediatrics | All other clinical service contexts | Not known | Total | Per cent |
|----------------------|------------|------------|-----------------|--------------|-------------|------------------|------------|-------------|-------------------------------------|-----------|--------------|--------------|
| Less than \$10,000 | 75 | 39 | 58 | 43 | 20 | 22 | 17 | 2 | 124 | 36 | 436 | 26.6 |
| \$10,000—<\$30,000 | 103 | 80 | 61 | 30 | 34 | 28 | 41 | 12 | 170 | 18 | 577 | 35.2 |
| \$30,000—<\$50,000 | 15 | 15 | 18 | 17 | 14 | 9 | 5 | 4 | 36 | 4 | 137 | 8.3 |
| \$50,000—<\$100,000 | 45 | 53 | 43 | 18 | 22 | 14 | 7 | 6 | 75 | 10 | 293 | 17.9 |
| \$100,000—<\$250,000 | 13 | 20 | 6 | 15 | 10 | 4 | 3 | 3 | 39 | 5 | 118 | 7.2 |
| \$250,000—<\$500,000 | 6 | 13 | 1 | 5 | — | 2 | — | — | 16 | 2 | 45 | 2.7 |
| \$500,000 or more | 4 | 11 | 1 | 1 | 3 | 1 | — | 1 | 6 | 7 | 35 | 2.1 |
| Total | 261 | 231 | 188 | 129 | 103 | 80 | 73 | 28 | 466 | 82 | 1,641 | 100.0 |

Notes

1. The clinical service context categories listed separately here are the eight most frequently recorded categories; all other categories are combined in the row labelled 'All other clinical service contexts'. Appendix 3, Table A3-1 shows frequency of coding categories for all clinical service contexts.
2. Data for approximately 80% of all claims are included.